Summary of Benefits: PPO Program

PPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider [1,2] (In-Network)	**Nonpreferred Provider[1,2] (Out-of-Network)**
Calendar Year Deductible [1] (Family deductible is an aggregate of three times the Individual amount and may be met by three or more family members.)	$250 Individual/ $750 Family	$500 Individual/ $1,500 Family
Calendar Year Out-of-Pocket Limit [2] (Includes deductible, copayments, and percentage coinsurance amounts **except** out-of-network inpatient hospital, residential treatment center, and drug plan copayments. Family limit may be met by three of more family members.)	$3,000 Individual/ $9,000 Family	$6,000 Individual/ $18,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited	**$2,000,000**
Office Visit/Exam Charge Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible, copayment, and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee.)	$20/visit *(deductible waived)*	40% after deductible
Family Planning: Office visit Sterilization/surgery (reversal not covered); other related services in office (IUD, diaphragm, Depo-Provera)	$20/visit *(deductible waived)* 10% after deductible	40% after deductible
Allergy Injections (only) and Immunizations (only)	No copay (*deductible waived)*	40% after deductible
Other Allergy Care (such as allergy testing; extract preparation)	10% after deductible	40% after deductible
Therapeutic Injections; Office Surgery and Supplies	10% after deductible [4]	40% after deductible [4]
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible [4]	40% after deductible [4]
Nutritional Counseling **(3 sessions/life** for certain conditions)	$20/visit *(deductible waived)*	40% after deductible
Routine/Preventive Well-Baby Care (Through Age 2): Including check-ups, routine screenings; routine laboratory tests; immunizations	No Copay (*deductible waived)*	40% (*deductible waived)*
Routine/Preventive Well-Child Care (Ages 3-18): Including routine physicals and exams, vision/hearing screenings; well-child care; immunizations	$20/visit *(deductible waived)*	40% after deductible
Routine/Preventive Adult Care (Ages 19 and Older): Including routine physicals and gynecological exams; routine colonoscopies; immunizations	$20/visit *(deductible waived)*	40% after deductible
Routine/Preventive Lab, X-Ray, Other Testing (Ages 3 and Older): Including routine Pap tests, mammograms, cholesterol tests, urinalysis, EKGs, etc.	No Copay (*deductible waived)*	40% after deductible
OTHER MEDICAL/SURGICAL SERVICES		
Acupuncture (limited to **20 visits**/year)	$20/visit *(deductible waived)*	40% after deductible
Ambulance: Emergency Transport (Air/ground ambulance, as needed)	10% after PPO deductible[3]	
Ambulance: Nonemergency Ground Transfer (between facilities)	10% after PPO deductible[4]	
Ambulance: Nonemergency Air Transfer (between facilities)	10% after deductible[4]	40% after deductible[4]
Cancer/Congenital Heart Disease Care (Blue Distinctions programs include a food/lodging per diem benefit of **$50/**person or $100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, per place of treatment, provider contract and type of service.)	10% after deductible[4,5]	40% after deductible[4,5]
Cardiac Rehabilitation, Outpatient/Office	$20/visit *(deductible waived)*[4]	40% after deductible[4]
Dental/Facial Accident[3], Oral Surgery, TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefit booklet for details)	Usual benefit based on type/place of service[4]	40% after deductible[3,4]
Emergency Room Visit (*emergency* condition only)	$75/visit *(deductible waived)* [3]	
Physician and Other Professional Provider Charges	10% after PPO deductible [3]	
Hearing-Related Services -Office exams and evaluations; cochlear implant; auditory testing -Hearing aid services (maximum benefit of **$2,200** during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible

This is a summary ONLY of benefits available under the PPO Medical Program. Conditions of coverage, limitations, and exclusions apply. See a benefit booklet for details.

PPO Medical Program Covered Services and Limitations (continued)	Member's Share of Covered Charges Preferred Provider [1,2] (In-Network)	Nonpreferred Provider[1,2] (Out-of-Network)
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency):		
- Skilled nursing services (Out-of-network limited to **$8,000/**calendar year)	10% after deductible[4]	40% after deductible[4]
- Other home health care agency services and home I.V. services (Out-of-network limited to **100** visits/calendar year)	10% *(deductible waived)* [4]	40% *(deductible waived)* [4]
Hospice Services including bereavement counseling when such services are provided by hospice (Lifetime benefit for hospice care limited to **$7,400;** respite care limited to **10 days** for each 6-month benefit period.)	10% *(deductible waived)* [4]	40% *(deductible waived)* [4]
Hospital/Other Facility: Inpatient		
- ***Medical/Surgical Acute Care, Observation, Medical Detox, Maternity-Related*** (including routine newborn nursery charges), *and* ***Extended Stay (Nonroutine) for Covered Newborn:*** Room and Board and Covered Ancillaries	10% after deductible[5]	$250 + 40% after deductible[5]
- ***Birthing Center***	10% after deductible	40% after deductible
- ***Skilled Nursing Facility*** and *Inpatient* ***Physical Rehabilitation*** (max. **100 days** per calendar year for preferred and nonpreferred combined; in addition, nonpreferred services cannot exceed **70 days** per calendar year)	10% *(deductible waived)* [5]	40% *(deductible waived)* [5]
- *Inpatient* ***Physician's Medical Visit*** *or* ***Consultation***; *Routine Inpatient* ***OB/Gyn Global Delivery Fee*** (includes pre-natal/post-natal care); *Inpatient Newborn Male* ***Circumcision***	No copay *(deductible waived)*	40% after deductible
- *Inpatient* ***Surgeon, Anesthesiologist, Radiologist, Pathologist,*** *and* ***Assistant Surgeon*** (including maternity services not part of OB/Gyn global delivery fee and all complications of pregnancy, such as C-section)	10% after deductible	40% after deductible
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (Includes covered services, whether billed by facility or professional provider, including surgery, diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]	40% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; EKGs, etc. - *Office or Freestanding/Independent Facility* - *Outpatient Hospital*	10% after deductible[4]	40% after deductible[4]
Short-Term Rehabilitation, Outpatient and Office (Includes outpatient and office physical, occupational, and speech therapy services, each of which is limited to **20 visits**/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	$20/visit *(deductible waived)* [4]	40% after deductible[4]
Spinal/Osteopathic Manipulation (Max. **20 visits**/calendar year)	$20/visit *(deductible waived)*	40% after deductible
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies. Support hose limited to **6** pair/year. Mastectomy bras limited to **3/**year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible [4,6]	40% after deductible [4,6]
Surgery: Outpatient Hospital, Ambulatory Surgery Facility, or Office: including facility and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible [4]	40% after deductible [4]
Therapy: Chemotherapy, Dialysis, and Radiation - *Office or Freestanding Clinic* - *Outpatient Hospital*	$20/visit *(deductible waived)* [4] 10% after deductible [4]	40% after deductible [4]
Transplant Services: Limitations apply to donor charges and travel, food, and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. Benefits for bone marrow/stem cell donor search limited to **$25,000** in a lifetime.	10% after deductible [4,5]	No benefit
Travel, Food, and Lodging: Benefits are available when these services are related to case-managed Cancer Services, Congenital Heart Disease, and Transplant Services if patient is receiving treatment from a Blue Distinctions Center for Specialty Care. Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision.		
Travel to and from health care facility plus per diem payments listed below	$10,000/lifetime after PPO deductible[4]	
Food and lodging **per diem** for patient and/or companion(s)	$50/individual or $100 for 2-3 persons after PPO deductible[4]	
Urgent Care Facility	$20/visit *(deductible waived)*	40% after deductible
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible	40% after deductible

PPO Medical Program Covered Services and Limitations (continued)	Preferred Provider [1,2] (In-Network)	Nonpreferred Provider[1,2] (Out-of-Network)
BEHAVIORAL HEALTH: Mental Health and Chemical Dependency		
Mental Health Services		
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]	40% after deductible[4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible[5]	$250 + 40% after deductible[5]
- Related Physician Claims	No copay *(deductible waived)*	40% after deductible
Chemical Dependency Rehabilitation		
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]	40% after deductible [4]
- *Outpatient/Suboxone Treatment*	10% after deductible [4]	40% after deductible [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible [5]	$250 + 40% after deductible[5]
- Related Physician Claims	No copay *(deductible waived)*	40% after deductible
- *Residential Treatment Center* (max. **130 days**/lifetime), including physician	$250 facility copay plus 20% after deductible [5,7]	$250 facility copay plus 40% after deductible [5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines [8]			
Enteral nutritional products, compounded medications, special medical foods, and other drugs require prior approval or benefits will be denied.	Generic Drug	Brand-Name Drug [8]	
		On Drug List	Not on Drug List
Retail Pharmacy/Specialty Pharmacy Programs (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines, for which no copayment is required)	$15	$30	$45
Mail-Order Program (up to a 60- or 90-day supply or 540 units, whichever is less)	$30	$60	$90
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires prior approval)	$45 retail/$90 mail-order		

FOOTNOTES:

1 All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made. Charges for preferred provider services do *not* cross-apply to the nonpreferred provider deductible, nor vice versa.

2 After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of that member's (or family's) covered charges for the rest of the calendar year (except for items covered under the drug plan, out-of-network inpatient hospital copayments, and residential treatment center copayments). Deductible, coinsurance, and copayments for preferred provider services do *not* cross-apply to the nonpreferred provider limit, nor vice versa.

3 Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment from a nonpreferred provider and treatment that is not for an emergency is paid at the Nonpreferred Provider level.

4 Certain services are not covered if prior approval is not obtained from BCBSNM (or Mesa Mental Health). A list of services requiring prior approval is in the benefit booklet. Some services may require a written request for prior approval in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.)

5 Admission review is required for inpatient admissions. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures, benefits for any related admissions will be denied. The $300 penalty will not apply in such cases. A $300 penalty for covered out-of-network facility services applies if approval is not obtained.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 Extended care facilities (such as nursing homes and residential treatment centers) are **excluded** from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to 130 days of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.

8 Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require prior approval before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.